

Office of Health Care Quality

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>02AL0240</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/08/2014</b>
NAME OF PROVIDER OR SUPPLIER  <b>HEART HOMES AT LINTHICUM II</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>804 CAMP MEADE ROAD LINTHICUM, MD 21090</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
E 000	<p>Initial Comments</p> <p>On May 8, 2014 an Inspection of Care survey was conducted by representatives of the Office of Health Care Quality (OHCQ) to determine whether the immediate health and safety needs of the residents are being met and determining compliance with COMAR regulations 10.07.14, Assisted Living Program Regulations.</p> <p>Survey activities included a review of selected administrative, staff and residents' files, interview with staff and residents, observations, and a tour of the facility. The facility is currently in the process of using the new Service Plan template to update all Service plans.</p> <p>The facility census at the time of the survey was sixteen (16) residents.</p> <p>Based on survey findings, the facility was found to be in compliance with the regulations governing assisted living facilities, COMAR 10.07.14.</p>	E 000		

OHCQ  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE